QUESTIONS AND ANSWERS FROM PROVIDER STANDARDS TRAINING

ADMINISTRATIVE RULE

1. Need registry for non-CNA employees so that termination due to neglect or abuse will prevent them from being employed in a similar agency.

   Agree that this would be helpful for providers. However, there are many issues with this such as who would build it, manage it, and have the ability to update it. Additionally, there are significant legal ramifications.

2. Am I to interpret this as everyone in management, administration, and provision of services must have a report from State Nurse Aid registry... even if they have never been a nurse?

   Yes, that is how you are to interpret that section.

APPROVAL/RENEWAL PROCESS

1. What is the timeline for current providers to apply to BDDS and the CRFC for approval?

   All providers will be automatically approved for either 1, 2, or 3 years effective Jan. 1, 2003.

2. Will providers have to discontinue services on 1-1-03 if they are not approved?

   See number 1 above.

3. Does this mean that the targeted case manager needs to be aware of when a provider is up for renewal? Or do targeted case managers also have a renewal date?

   IAC 6-4-1 includes targeted case managers as a provider of supported living services and supports. Targeted case managers will have a renewal date.

BEHAVIORAL SUPPORT SERVICES

1. When behavioral support services person take individuals out to lunch, grocery, shopping for new phone, the fair, other shopping, to park and on and on - how is state going to make sure that they are doing behavior work? Functional behavioral analysis is what is needed. What do we do if the behavioral support services person does not train?

Every attempt should be made to resolve this issue at the local level, working with the provider of behavioral support services, the targeted case manager and the local BDDS office. If the issue can not be resolved, then a complaint can be made with BQIS or the DD-Waiver Ombudsman.

2. Will a person with a Master's Degree in Agency Counseling meet the requirement?

   No. An individual has to have a master's degree in psychology, special education or social work.

3. Will there be consideration regarding course work if the actual degree is not psychology, special education or social work?

   Not at this time.

4. Can we exceed the Level 1 standard? - No HSPP but have a psychiatrist doing oversight. Is that ok?

   460 IAC 6-5-4 states that the qualifications for Level 1 are to be a licensed psychologist and have an endorsement as a health service provider in psychology. Having no HSPP and having a psychiatrist doing oversight would not meet the standard.

5. QMRP's have been writing behavior plans with approval quarterly from psychologist evaluations. Is that still acceptable or are we now asking our psychologists to write behavior pans with functional analysis?

   There is no reference in the rule for a QMRP to write the behavioral support plan. If the QMRP met the requirement of a level 2 clinician, then they could write the behavioral support plan and it would have to have written approval by the Level 1 clinician and they would have to be supervised by a Level 1 clinician.

6. I am a Social Worker, MSW, LCSW and have done Behavior Plans for 8 years and I am paid by insurance e.g. BCBS and do not have HSPP. This does not make sense.

   You can continue to write behavioral support plans as long as you met the requirements for a Level 2 clinician.

7. What plan does BQIS have to make Ph.D.'s available to allow providers to deliver behavioral services? If the Indiana Psych. Association presence was instrumental in driving this rule – what answers do they have to allow providers access to Ph.D's in rural settings and paying for Ph.D's if one can not be found?

   DDARS has been working closely with the Indiana Psychologists Association to make every effort to have the resources to meet the needs of individuals. In

addition, the Bureau of Developmental Disabilities Services is making every effort to approve Level 1 clinicians as quickly as possible.

8. Who is responsible for behavior plan training with staff in the home? Would it be provider staff or the behavior specialist that wrote the behavior plan?

   460 IAC 6-18-2(g) indicates that the behavioral support plan is to contain documentation that each person implementing the plan has received specific training as provided in the plan in the techniques and procedures required for implementing the behavior support plan.

9. Does "seclusion" include timeouts?

   460 IAC 6-9-3(c)(2) prohibits seclusion, identified as placing an individual alone in a room or other area in which exit is prevented. If an individual needed "time out", this would be acceptable as long as the area had an exit and it was in accordance with the behavioral support plan.

10. When a behavior specialist writes a plan and staff from that same provider implement the plan – is it billed at the same rate? Shouldn't they be training staff or residential provider rather than working directly with the individual?

    460 IAC 6-18-2(g) indicates that the provider of behavioral support services is to assure that the plan contains documentation that each person implementing the plan has received specific training in the techniques and procedures required for implementing the behavioral support plan.

11. What are the requirements for a Behavioral Clinician who works independent (not employed by a company)? Requirements before June 1, 2003 and after that date.

    Any independent behavior support service's clinician will have to meet the requirements for either a Level 1 or Level 2 clinician.

12. If an "independent" behavioral support service's clinician is working on a Masters in Psychology (currently has a BS in an unrelated field) but is not employed by an approved provider (Behavior Company) because they are independent – are they qualified?

    No.

13. Is a psychologist to be a waiver provider?

    Yes, the Level I Clinician (Psychologist) must be an approved provider.

14. Can we get a listing of Level 1 providers?

    Yes. A list can be obtained from INsite using the Medicaid Waiver Provider icon. Use the process as you would if obtaining the targeted case manager pick list.

15. Is it the responsibility of the Behavior Specialist to set up the documentation system in the Behavioral Support Plan and the responsibility of the provider to maintain the tracking? Or does the provider do both or neither?

    460 IAC 6-18-2(h) state that the behavioral support services plan is to contain a documentation system for direct care staff working with the individual to record episodes of the targeted behavior or behaviors.

16. Behavior Specialists have requirements – why aren't schools held to the same requirements? Schools develop behavioral support plans all the time, especially the autism coordinator, without these requirements.

    We do not regulate the requirements for schools.

17. Can a Behavioral Support person who is receiving funding from a waiver go into the school and develop a support plan using waiver funding?

    No, this is the responsibility of the education system.

18. Is there a time frame behavior support staff has to complete behavioral support plan – some of these take months.

    The specific time allowed would vary, depending on the needs of the individual and the specific situation. It should not take months to set up a plan, however. It is the responsibility of the targeted case manager to assure this is completed in a timely manner, or the BDDS Service Coordinator if there is not targeted case manager and the QMRP of an large private ICF/MR setting.

19. Are Behavior Consultants required to be working on their master's degree or are they only going to be decertified once the 12-31-06 deadline occurs?

    460 IAC 6-5-4(c)(1)(B)(iii) indicates that an individual must be working on their masters.

20. Can individuals who are not behavioral specialists still write behavior guidelines as opposed to behavior plans?

    There is no reference in the rule for behavioral guidelines. There is only reference to behavioral support plans.

TARGETED CASE MANAGER MONITORING RESPONSIBILITIES

1. What if the family does not want you to do quarterly reviews in their home? Can we just document the request for this?

   Guidance have been provided in correspondence from Chris Newman, Director of the Bureau of Quality Improvement Services, that the 90 day checklist does not need to be completed in the individual's home if the individual is receiving no services in their home. This is the only exception. Targeted case managers are expected to otherwise comply with the standards set out in 460 IAC 6-19-6.

2. Have some individuals who will not allow us access inside of their home – how do we deal with this in meeting standards?

   Targeted case managers are required to abide by the standards established in 460 IAC 6-19-6.

3. In making the shift from Title XX to the Support Services Waiver we have individuals and their families who now feel that their rights are being violated. For instance, under Title XX were no TCM visits but now have these. There is a lot of frustration of individuals with this shift in funding and changes in the rules.

   Targeted case managers are required to abide by the standards established in 460 IAC 6-19-6. It is important that we maximize the resources associated with the Support Services Waiver. Families should be informed that this is a more cost effective mechanism in which to provide services and understand the associated requirements of contacts with the individual's targeted case manager.

4. Concern unannounced – for some individuals/families means I visit in the middle of night due to work schedules.

   Targeted case managers are required to abide by the standards established in 460 IAC 6-19-6.

5. How long is "face-to face"?

   This would be determined by the needs of the individual.

6. Since a Targeted Case Manager is responsible for monitoring etc. should they not have some intensive Quality Assurance training to effectively do this? BQIS staff have this training to do Quality Assurance/Quality improvement monitoring. It would seem that Targeted Case Managers should have something so that standards are interpreted uniformly.

This will be communicated to the Bureau of Developmental Disabilities Services as they develop case management training courses.

7. Should the TCM have all seizure records in addition to the person named in the ISP?

   460 IAC 6-25-7 indicates that the individual's health care coordinator is to design a system of seizure management for the individual, which is to include a system for communication among all providers working with the individual. There is no requirement that the targeted case manager have all seizure records.

8. If you are subcontracted through a TCM agency and the contract you sign states that you are not considered an employee of the agency then who is responsible to keep personnel records on the TCM?

   The requirements for personnel records are applicable to all employees and agents. In this case you would be considered an agent and the entity that you are contracted with would have this responsibility.

9. How will accommodations be made for targeted case managers with physical disabilities in terms of requirements for CPR etc.?

   Accommodations will be considered based upon the unique circumstances of each case.

10. What recourse does a targeted case manager have when required information is not being provided by the other providers?

    460 IAC 6-10-8 identifies the steps to be taken in resolution disputes.

11. Providers are required to keep 60 days of documentation in the home but targeted case managers are required to review 90 days worth of this information?

    That is correct.

12. Will targeted case managers have access to an individual's financial statements?

    460 IAC 4-24-2 identifies that the individual's residential living allowance management services provider or the individual identified in the ISP as being responsible for an individual's property or financial resources is to maintain separate accounts for each individual and provide monthly account balances and records to the individual or their legal representative. As a targeted case manager, you are responsible for monitoring and documenting the quality, timeliness and appropriateness of the care, services and products delivered to

an individual. If a targeted case manager needed to see the financial statements in completing their responsibilities, then this should be done.

13. Should a targeted case manager report to APS/CPS if they feel an individual is at danger by not meeting the physical environment rule? e.g no fire extinguisher but family member smokes.

    The targeted case manager needs to use their professional judgement in determining when it is appropriate to refer an allegation of abuse, neglect or exploitation to APS or CPS.

14. I am a targeted case manager for a provider and my clients receive no in-home services – how do I make unannounced visits to the homes?

    Targeted case managers are required to abide by the standards established in 460 IAC 6-19-6.

15. 6-19-7 – conflict of interest – does this mean that a provider of targeted case management services can not provide any other services to that individual? Or just the individual providing case management services?

    460 IAC 6-19-9 refers to the person.

16. Does the 30 day visit after implementation of the ISP need to be made only on the initial Individualized Support Plan? Does it also need to be made 30 days after an update/annual?

    This will be clarified in technical amendments, however it refers only to the initial ISP.

17. Is the targeted case manager responsible for ensuring that providers follow all the rules in each area or will this happen when providers are surveyed?

    The targeted case manager is responsible for monitoring and documenting the quality, timeliness and appropriateness of the care, services and products delivered to an individual. The Bureau of Quality Improvement Services, as the designee for the Bureau of Developmental Disabilities Services, is responsible for monitoring compliance with the requirements of 460 IAC 6.

18. Appointments need to be made around a provider's schedule. We have several staff who work with more than one individual and they have prior engagement with one of these other folks. Do we need to have an individual sign an agreement letting them know that appointments must also be made around staff schedules?

    There is a need for collaboration and coordination among all providers.

19. Need to clarify whether any Support Team 90-day reviews need to occur in the home as long as the targeted case manager has met the standards for face-to-face home visits. Many times the IDT is quite large and meeting in an individual's home is not always ideal or appreciated by the individual.

    Rule 17 refers to maintenance of records of services provided and applies to all supported living supports and services. There is no reference to the individual's support team.

20. Is the BDDS approved course in case management for all targeted case managers now or just for new ones from this point on? Is this for support services waiver case managers as well.

    It is for all targeted case managers and this includes those working with individuals receiving services from the Support Services Waiver.

21. Is the requirement to be a targeted case manager to have a BS or a BA?

    BA – the slide shown during the training was incorrect.

COMMUNITY RESIDENTIAL FACILITIES COUNCIL

1. What is this? What is their role and who is on the committee?

   This is the council that has been approving Supervised Group Living providers. In 2001 they were given authority to approve all supported living providers and establish standards in conjunction with BDDS. Therefore, this council must approve all applications and renewals. The council is made up of individuals from the Office of Medicaid Policy and Planning, Indiana State Department of Health, providers, individuals from the community, family members, etc.

2. Does this pertain to targeted case managers? CM administration?

   It applies to both.

COMPLAINTS

1. How is the person who makes complaint protected from retaliation of provider? How is individual protected? What guarantees does BQIS give? Do you protect job? Do you protect references? What is the confidentiality re: standards? What process is in place to make sure BQIS looks at financial issues?

   The Bureau of Quality Improvement Services does not typically address where a complaint may have come from, although this is public information. Targeted case mangers must use their professional judgement in making

complaints and keep in mind that the responsibilities for the monitoring of services.

2. If a complaint is filed against a CM – is the CM informed of the complaint so their input is considered?

   Yes.

3. If there are many concerns for the quality of the CM services, who does the provider contact on this issue?

   Every effort should be made to resolve any issues at a local level. However, a complaint could be made to the Bureau of Quality Improvement Services.

4. What is the recommendation for independent targeted case managers an establishing an internal complaint process?

   The Bureau of Quality Improvement Services will be providing more information relating to best practices in developing an internal complaint process. However, at a minimum this should include establishing a system to register a complaint, the documenting of the any investigation, timeframes and how information will be shared.

5. Can a targeted case manager ask to see a provider's internal incident report when it is in question?

   Yes.

CONFLICT OF INTEREST

1. Are targeted case managers allowed to do direct care for individual that they do not do case management for?

   Yes.

CORRECTIVE ACTION

1. Is the Plan of Correction done by the targeted case manager or a combination of service providers?

   Any plan of correction is to be completed by whoever was cited.

CRIMINAL HISTORY CHECK

1. How wide an area check is required in the criminal history check – is it state or local?

Per the standards, the limited criminal histories are to be obtained from the Indiana State Police Central Repository for Criminal History. This is a statewide (Indiana only) criminal history check. It is also recommended that a county check be completed and a check in another state if the individual has worked in another state. This is an area that we will be evaluating in terms of any technical amendment needs to the rule.

2. Can certain types of felonies be accepted? What is the timeline on felonies?

   Refer to 460 IAC 6-10-5 for a list of offenses that <u>are not</u> acceptable. According to the Indiana State Police, if an individual is <u>convicted of</u> a felony, it will permanently show up on the criminal history check.

3. Are these criminal history checks every three years?

   6-15-2(b)(4) indicates that there is a need to update information at least every three years. If you have knowledge of an offense, you should update the check and respond accordingly.

4. Can targeted case manager have access to criminal history check information obtained by another provider?

   This is not covered by the standards. A targeted case manager would need to work with the provider to determine this.

5. We have heard from agency attorney that it is not legal to obtain criminal background checks after initial one is done upon hiring the individual. If this is true, how can we obtain checks every three years?

   This has been heard on several occasions, however, we are not able to ascertain what this is based upon. If more information is available, please supply it.

7. I just reviewed the new BDDS Service Definitions and am wondering if there are any guidelines on how frequently we need to do the required checks on employees, such as Bureau of Motor Vehicle Check, Criminal check (we are currently doing those every 3 years), and Nurse Aide registry check

   460 IAC 6-15-2(b)(3) specifies that an auto insurance information is required annually if the employee or agent will be transporting an individual in his/her personal car.

   460 IAC 6-15-2(b)(4) specifies that limited criminal history checks are to be completed at least annually, as is the nurse aide registry check.

6. Are targeted case management entities required to do criminal background checks on case managers being hired? If not, why not?

   Yes, they are required to do these checks.

7. Does it mean that anyone that was hired since 1999 needs to have criminal history checks completed or is this effective 1/1/03? Same with CAN checks.

   As of 1/1/03 all employees or agents are to have criminal history checks.

DISPUTE RESOLUTION

1. Is there a timeline for decisions to be made along the process?

   There is no time frame identified in the rule, however every attempt should be made to resolve the issue as quickly as possible to assure the provision of quality services for an individual.

DOCUMENTATION

1. Having all this documentation on each individual in his/her residence is a logistical nightmare. Why can't this information be in a master file in a central location that is not at the individual's apartment? You tell us to maintain a residence that is homey and non-institutional yet by complying to all these standards (paperwork) you create what you tell us not to create.

   Staff working with individuals need access to records in order to provide consistent continuity of care. All providers need to be aware of an individual's needs and outcomes as documented in the ISP. Providers need access to the individual's ISP and/or behavioral support plan so they can implement the plan.

2. If an employee has a positive TB test, do they need to get a chest x-ray every year?

   460 IAC 3-15-2(b)(1) states that all staff are to have a negative tuberculosis screening prior to providing services and updated in accordance with the recommendations of the CDC. If someone has a positive test, then they are not to be providing services and supports.

3. IAC 6-17-3 and 4 address the requirements for individual personal files that are to be maintained on site and in the office. The on-site file must contain 60 days worth of documentation, with the rest of the information to be maintained in the office file. Is the 60-days a minimum? Can more than 60 days be kept on-site as long as between the on-site file and the office file, all information is complete?

Yes – 60 days is a minimum. More documentation can be maintained in the file on site.

4. Can 6-18-2 allow the documentation system to be the shift notes the direct care staff completes or does it have to be a separate system e.g. behavior data sheets?

   460 IAC 6-18-2 indicates that the documentation system is to include:
   1) **a method to record the dates and times of occurrence of the targeted behavior;**
   2) **the length of time the targeted behavior lasted;**
   3) **a description of what precipitated the targeted behavior;**
   4) **a description of what activities helped alleviate the targeted behavior; and**
   5) **the signature of staff observing and recording the targeted behavior.**

   This would be a separate documentation system than shift notes.

EDS REVIEWS

1. When EDS performs an audit, will they have this list of documentation requirements and be encouraged to follow it?

   Yes. In the future EDS will be completing fiscal reviews and BQIS will be completing surveys in accordance with 460 IAC 6.

2. When we received a Medicaid audit, the auditors were not happy that we were giving some individuals Range of Motion without MD or PT oversight. The actual citation was "No MD or PT evaluation for passive ROM". What is the expectation for individuals receiving ROM? An MD order? A PT/OT evaluation saying its needed?... how often are they expected to be involved?

   460 IAC 6-5-19 indicates that in order to be approved to provide physical therapy services, an applicant must be a physical therapist licensed under IC 25-27-1. There should be an evaluation of the need for passive ROM and there should be oversight by a PT.

3. Our agency had an EDS review. Per their interpretation – one unit of service is one visit with RN or LPN and 4 contacts with a professional i.e. physician, psychiatrist etc. What is your interpretation?

   According to the DD Waiver Manual, 1 unit equals 1 visit by a RN or LPN for at least weekly consultation and one face-to-face visit per month.

FINANCIAL MANAGEMENT

1. How does this apply to children living with families?

   It depends on who is taking responsibility for the task. If it is the parents, it does not apply. 460 IAC 6-24-3 refers to the "provider" identified in the individuals ISP as being responsible for an individual's property or financial resources. 460 IAC 6-3-42 indicates that the definition of "provider" is the person or entity approved by the BDDS to provide the individual with agreed upon services. Family members that are not approved providers of services are not subject to the requirements of 460 IAC 6-24-3.

2. Do there need to be records of financial transactions in the home?

   460 IAC 6-17-3(b)(10) indicates that if an individual's goals include bill paying and other financial matters, the individual file in the home or the primary location where the individual receives services is to include the individual's checkbook with clear documentation that the checkbook has been balanced and bank statements with clear documentation that the bank statements and the individual's checkbook have been balanced.

3. In managing the finances with the team – will the targeted case managers be required to complete a quarter financial audit similar to the pilot in District 1?

   That is currently a pilot and no decision have been made.

4. Some are saying that individuals have to have the bank statements and checkbooks in the home. If summary of finances – I understand being in the home. But the rest is taking a chance of others having access and exploiting the finances. As long as they are available for families and the case manager to see – why leave them in the home.

   460 IAC 6-17-3(b)(10) indicates that if an individual's goals include bill paying and other financial matters, the individual file in the home or the primary location where the individual receives services will include the individual's checkbook with clear documentation that the checkbook has been balanced and bank statements with clear documentation that the bank statements and the individual's checkbook have been balanced.

5. Have problems if receipts are to be left in the home – there are instances where even the individual will take the receipts that were used to buy good food and return the food for things that they should not have.

   Records of transactions are required per 460 IAC 6-24-3 to be provided to the individual on a monthly basis and 460 IAC 6-17-3 does not refer to receipts for items purchased.

6. If the support team determines that someone is responsible for their own finances – does their have to be a monthly audit?

   No, it does not have to be completed by individuals themselves.

7. If an unpaid person (family) takes on this responsibility (for financial or medication management) they should be clearly informed and trained if needed, so they can be held accountable or team can appoint someone else if they do not meet standard.

   Family members and individuals are not providers of services as included in the definitions in 460 IAC 6-3-42 that are required to abide by these standards. The targeted case manager should assure that non providers who are providing a support service to an individual such as financial or health care management are providing the support in a manner that meets the needs of the individual and document actions taken when the provision of services is not meeting the needs of the individual.

8. Do these standards give any guidance on who can pay for what e.g. food that staff eats should not be purchased by the individual etc.

   460 IAC 6-24-3(c)(3) indicates that if the provider is responsible for management of an individual's funds, the provider is to inform the individual or the individual's legal representative, if applicable, that the payee is required by law to spend the individual's funds only for the needs of the individual.

9. If individuals have budgeting goals with objectives for maintaining receipts or bill identification but have not achieved a skill level to pay bills or maintain a checkbook, does the requirement to have checkbook in the home still apply? Can it be made available during a BQIS review? Does noting skill level in the Individualized Support Plan apply here.

   460 IAC 6-17-3(b)(10) indicates that if an individual's goals include bill paying and other financial matters, the individual file in the home or the primary location where the individual receives services is to include the individual's checkbook with clear documentation that the checkbook has been balanced and bank statements with clear documentation that the bank statements and the individual's checkbook have been balanced.

HEALTH CARE COORDINATION

1. If the family oversees the health care coordination, but there is HCC as a service, who is responsible for keeping the records?

   If an individual is receiving Health Care Coordination Services, then the provider of such is responsible for complying with the requirements of Health Care Coordination in 460 IAC 6. The Individualized Support Plan would need

to identify the provider of Health Care Coordination Services as the provider responsible. A family member could not be identified.

2. Is anything being done to address an incentive for health care agencies to abide by these standards? With more requirements we will have fewer providers in this needed area.

   There is no special incentive plan for health care agencies. They will be monitored as with all other providers and cited when out of compliance.

3. If individuals are to have annual check ups etc – what if the family refuses? Do we just document education attempts etc.?

   Coordination of annual physical exams is required only when ordered by the physician. (IAC6-25-2) If the family is the coordinating the individual/s health care and refuses to take the individual to the doctor as ordered by the individual's doctor, then it may be in the best interest of the individual for the support team to get together and discuss the individual's health needs with the family. You would need to document all attempts, and depending on the health status of the individual, you may also need to consider filing an incident report.

4. Can a registered nurse become a health care coordination provider?

   Yes.

HUMAN RIGHTS COMMITTEE

1. All of these questions will be addressed in a separate document.

INCIDENT REPORTING

1. Can BQIS investigate the method that a provider uses to file incident reports, if that provider has a history of wrong information (such as wrong name of the individual) or not sending all necessary parties a notice or copy of the incident report?

   Yes, if this were noted to be a systemic problem.

2. Home health agencies need training on incident reporting.

   Special training is being planned for these entities in the near future.

3. Suspended from duty – from work completely? Can the person be relocated to an area were there is no direct contact with individuals? We have individuals who regularly make claims that are then unsubstantiated. Do we have to suspend completely?

The expectation is that the individual would be suspended from any work associated with that provider.

4. What affect does suspension have on DOL regulations? Unemployment etc?

   You would need to consult with your personnel resources or legal resources.
5. If we suspend – are we suspending from that funding source? For instance, if the individuals claiming abuse is funded under waivers – can we relocate this person to a different funding source (SGL, respite etc?)

   The expectation is that the individual would be suspended from any work associated with that provider.

6. Does the reporting of deaths include individuals on the A&D waiver?

   460 IAC 6 does not apply to the Aged and Disabled Waiver.

7. If incident report is done by provider then it is TCM who will do 7 day follow-up, but what about if no TCM – would the BDDS Service Coordinator then follow-up or the provider?

   The identified targeted case manager is responsible for doing all follow up reports when the individual is receiving case management services. The QMRP of any large private ICF/MR setting is responsible for completing follow up reports for any reports submitted for individuals receiving services from this source. For all other incidents, the BDDS Service Coordinator is responsible for the completion of any needed follow up reports.

8. How long does it take for CM to be notified if follow-up has been received and whether it is acceptable?

   You will not receive any correspondence back when filing via the fax or e-mail. When filing via the web, you will get a confirmation screen that states that the report was successfully transmitted. Once the report is accepted at BQIS, you will get an e-mail reply stating that there is follow up needed or that the report is closed.

9. If a family gives PRN and no provider is involved – does this need to be reported? If yes, how is it monitored?

   If you are aware that a PRN was given for behavioral reasons, or become aware of any reportable incident, it is to be reported within 24 hours of becoming aware of the incdent.
10. It seems that you want the targeted case managers to be available 24/7 but the same is not expected of BDDS. Why the double standard?

The 24 hour reporting criteria is designed to assure that all providers, and, as applicable APS, CPS and legal representatives, are notified of a reportable incident as soon as possible and are able to address any issues as needed. The targeted case manager has the responsibility to monitor the provision of services, so this is particularly important.

11. We have situations in which individuals make multiple false reports on staff abuse etc. If someone has a history of this can it be addressed in the Individualized Support Plan that in certain situations staff would not be suspended?

    460 IAC 6-9-5(a)(1) states that any alleged, suspected, or actual abuse, neglect, or exploitation of an individual is a reportable incident. The provider is also to suspend staff involved in an incident from duty pending investigation. There is no allowance in 460 IAC 6 for any exceptions.

12. PRN medications used for anxiety symptoms related to anxiety attacks (not associated with medical appointment) are given as needed – is this reportable?

    All PRNs are reportable unless given for anxiety due to dental or medical appointment.

13. Regarding a death – what if individual is their own health care representative?

    Per 460 IAC 6-25-10, if the provider identified as the provider of health care coordination services is a family member, then the provider of case management services to the individual shall conduct an investigation into the death of the individual.

14. How long do we keep incident reports?

    460 IAC 6-17-2 (c) indicates that documentation related to an individual is to be maintained for at least seven (7) consecutive years.

15. Is it still a physician's role to determine if a medication error/omission or refusal is reportable?

    Per 460 IAC 6-10-5(a)(12), a medication error, except for refusal to take medication that jeopardizes an individual's health and safety is reportable. The BDDS policy relating to the reporting of incidents indicates that contact with a physician should be made to determine if the medication error jeopardizes the individual's health and safety.

16. Do targeted case management agencies need to maintain a process to analyze data on reportable events?

    Yes.

17. Our company trains direct care staff to report alleged mistreatment to their supervisor, the house manager or some other manager/administrator. Do direct care staff have to report directly to Adult Protective Services, Protection and Advocacy etc. or can they still follow the company's directive and report to company staff only?

    There is no reference in 460 IAC 6 in terms of the provider's internal process to report.

18. An individual states "he hit me" 20 times a day. Does an incident report need to be completed for each instance? When staff question him, he always says no one hit him. Should we not be questioning him and file a report instead?

    Any alleged, suspected, or substantiated report of abuse is to be reported.

19. If a residential provider completes a BDDS incident report, then follow-up is to be completed by the targeted case manager. Does the targeted case manager make the follow-up report available to the provider that submitted the original report?

    Yes – the follow-up report needs to be sent to everyone who received the initial report.

20. Is every emergency room visit reportable? Take individual to ER and diagnosed with cold, gas or migraine.

    460 IAC 6-10-6(a)(7) indicates that any event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for an individual is reportable. Therefore, if it determined that someone needs to go to the emergency room, then the situation must meet needing immediate care and would be considered significant.

21. As a targeted case manager, I have found that I do not receive copies or even reports of the contents of "in-house" incident reports completed by agencies. It is not always a reportable incident to BQIS/BDDS. Can a targeted case manager ask for these?

    Yes, as a targeted case manager you are responsible for monitoring and documenting the quality, timeliness and appropriateness of the care, services and products delivered to an individual.

22. Is there a detailed list of what follow-up actions are needed for what types of incidents?

    At this time this is determined on an individualized basis.

24. Are home health agencies required to report?

Yes, specific training will be provided in the near future.

25. What is a PRN medication?

Medication taken, as needed.

INDIVIDUALIZED SUPPORT PLAN (ISP)

1. Is a provider agency's Individual Program Plan an acceptable substitute for the Individualized Support Plan?

   460 IAC 7 establishes the standards and requirements for the individualized support plan. It is anticipated that this rule will be fully promulgated by May 1, 2003 and it will mandate the format for the ISP for all individuals with developmental disabilities.

2. If an initial ISP needs to be held and the POC has a starting date of 7-1-02 (approved on 10-25-02 and Medicaid starting 9-20-02) should/could 7/1/02 be the date used for the ISP?

   There is no requirement that the POC and the ISP have the same start dates, although it would seem that this would be an efficient use of time.

3. As a TCM it is my understanding that I am responsible to write the ISP – who is supposed to write the ISP?

   460 IAC 7-4-1 states that the ISP is to be developed by an individual's support team and the support team is to be lead by a facilitator chosen by the individual. The rule goes on to explain the qualifications of a facilitator.

4. If writing an ISP prior to 1/1/03 then do those ISPs have to be re-written according to new ISP standards by a certain date? Can they be re-written according to new standards as they become due for renewal?

   It is anticipated that the ISP rule will be final in May 2003. At that time the PCP process and the use of the ISP will be required at the time that an individual's annual review is due or at any time in which there is a change in the individual's plan. At the time of a survey by BQIS, surveyors will be reviewing records (under the PCP/ISP process or other processes) to assure that all health and safety issues are addressed.

5. What is the "chain of command" for residential habilitation and support providers to obtain ISPs from targeted case managers? Especially from independent case managers?

At this time 460 IAC 7-4-3(b) states that the responsibility for assuring the dissemination of the ISP is the responsibility of the provider providing case management services to the individual if the individual receives targeted case management services.

6. Why are we as targeted case managers, required to send ISP to people other than the individual and the provider?

   460 IAC 7-4-3(b) was based on 460 IAC 6-19-6, which covers the case manager's role in assuring the quality, timeliness and appropriateness of care, services and products delivered to the individual.

7. How are the BQIS surveyors going to review the ISP prior to the survey when service providers are not able to get TCM to return calls or participate in the PCP/ISP?

   It will be the policy of the Bureau of Quality Improvement Services that surveyors will review the ISP prior to completion of any survey. 460 IAC 6 clearly states the role that targeted case managers are to have in the person centered planning process and the development of the ISP and targeted case managers will be surveyed based upon these standards.

8. If it is written in the ISP that the individual does not want unannounced visits, are we still required to comply with this standard?

   There is no exception in the rule regarding unannounced visits.

9. There is a lot of duplication - are their plans to combine the PCP and ISP?

   Person Centered Planning is the process that is being used. There is only one plan – the Individualized Support Plan.

10. I have an individual whose provider discourages staff from going to ISP's, PCP's etc., unless they are the staff on for that shift because there is no reimbursement for the additional staff. I am sensitive to the fact that not every staff person needs to be there, however, there are key staff that the family requests to attend. I realize it is not my place to tell this provider that they need to pay their staff for the time they spend there, however making it a voluntary, non-paid thing discourages staff from attending and their input is lost. I feel that if the consumer requests certain staff to be there, then the provider should try and accommodate that request. I was wondering if the standards address this and if I have any recourse.

    460 IAC 6 does not specifically address this. However, there is an emphasis throughout the rule on collaboration and cooperation.

11. How will BQIS review the ISP prior to visit? Will ISP be included in Insite?

    It is planned that the ISP will be available in the INsite and DART systems.

12. For individuals on the Support Services Waiver, a copy of the ISP is sent home, but I as a targeted case manager cannot guarantee that the individual and/or family keep it available or keep it at all. Is documenting that a copy was sent home enough to pass a survey?

    460 IAC 6-17-3(a)(1) indicates that the provider specified in the ISP as being responsible for maintaining the individual's personal file is to maintain that file at the individual's residence or the primary site of services. A copy of the ISP is to be included.

13. For people whose primary place of services is their employment – are they required to have a copy of their ISP on the job?

    Yes – see number 12, above.

14. Does the targeted case manager always complete the ISP?

    It is the responsibility of the targeted case manager to assure the completion of the ISP. It is up to the individual to choose who is to complete the ISP.

15. Should a residential provider include the targeted case manager if they are discussing an individual and they have a targeted case manager or potential housemates for this person?

    Yes – there should be collaboration and cooperation among all providers to best assure the provision of quality services to individuals.

MEDICATION

1. Are individuals living in their own home with no staff administering medications, required to follow the rules of medication storage etc. What if the parent gives the medication?

   460 IAC 6-25-4 states that the provider of health care coordination services is responsible for designing an organized system of medication administration. If the entity identified does not fall under the definition of a provider, then this standard would not apply. Family members and individuals are not providers of services as included in the definitions.

2. Are medication trays allowed if in ISP? Ex. person living alone, can't read, pills not all a different color so needs some guidance in self-administering.

460 IAC 6-25-4 indicates that if a person needs supports, such as the use of medication trays, then the ISP should spell out those supports.

3. Can a pillbox be used if indicated in ISP?

   460 IAC 6-25-4 indicates that if a person needs supports, such as the use of pill boxes, then the ISP should spell out those supports.

4. If a parent gives the medication, or an individual self-medicates, do they have to document on a medication log sheet?

   460 IAC 6-25-4 is applicable to providers only. If the entity responsible for health care coordination services is not a provider, then the standards do not apply.

5. If an individual takes psychotropic medication, is there a requirement for an AIMS test?

   An AIMS test is not mandated in the standards.

6. Why do individuals who live in their own home or apartments have to lock up medications?

   460 IAC 6-25-4(d)(7) indicates that medications are to be in a locked area, unless specified differently in the ISP.

7. Can you lock a roommate's medications in the same lockbox together or does each individual have to have their own lock box?

   This is not addressed by 460 IAC 6.

8. Do all staff have to be trained to pass medications or just staff who pass medications?

   All direct care staff as defined in 460 IAC 6-3-18.

9. How often do medication levels need checked for seizure medication? What if the doctor does not feel they need to be checked regularly but sees individual every two months and orders them as he feels needed.

   460 IAC 6-25-7(b)(4)indicates that there is a need for the seizure management system to include a check of the individual's levels of seizure medication at least annually or as ordered by the individual's physician.

10. What about requirements for medication administration for a child living at home with parents?

This would be dependent upon who is identified as responsible for health care coordination services.

11. Am I correct that unless the ISP indicates otherwise, that medication is to be in a locked area?

    Yes, and in original containers.

NUTRITIONAL SERVICES

1. Is a nutritionist required for all individuals' diets or only those people with special dining needs?

   460 IAC 6-26-1 indicates that if an individual is receiving nutritional counseling services, then they are to design and document a dining plan for an individual in accordance with the individual's ISP.

2. What about client "choice" in regard to nutritional counseling when provider wants to follow plan but client refuses? Menu plan is made at home prior to shopping but in store client decides to purchase unhealthy foods not on grocery list?

   This would need to be dealt with on an individual basis. Certainly the individual's support team should be addressing this type of issue.

3. Is this term being used like health care coordination? Someone has to oversee nutritional needs but it does not have to be a dietician?

   460 IAC 6-3-27 indicates that the provider of nutritional counseling services must be a licensed dietician. Not everyone with nutritional needs will have "nutritional counseling". This needs to be determined on an individual basis.

4. What if an individual has dining difficulties (requires pureed foods), lives with parents and does not require formal nutritional counseling services – should information regarding dining difficulties just be documented in the ISP or should an informal dining plan be attached to the ISP? Is so, would it be appropriate for the case manager or the support team to develop this informal dining plan with the case manager monitoring this?

   This is not addressed in 460 IAC 6. However, it would appear that this is something that the support team should address.

5. Are diabetic diets included under dining plans?

   They certainly could be if the individual is receiving nutritional counseling services.

OFFICE IN THE HOME

1. Can you have a locked bedroom for staff who sleep there?

   No.

2. Does this apply to homes owned by someone other than the provider?

   The standards in 460 IAC 6 are applicable to providers of supported living services and supports.

3. Is it ok to have a locked cabinet in a room?

   Yes, if for medications, confidential files etc. It is not acceptable if the intent is to lock up items belonging to staff.

4. Can we have a locked small refrigerator in the home for staff with special diets which for individuals who live there should not have access.?

   This would not be acceptable given the information provider here.

5. If the individual is profoundly disabled and not able or not interested in using an office – can there be one in the home? Could an office be set up in the corner of the living room?

   The significance of an individual's disability is not a consideration. 460 IAC 6-10-11 clearly states that there can only be an office in the individual's home if the individual has equal access to that area. If this requirement is met, then there should be no difficulty in being in compliance with the standards.

6. Why is it such a big deal to have one locked room in the house? Many folks do not allow their kids in "dad's den". Why does the state make it so difficult to be a case manager?

   The issue is that this is the individual's residence, and they are paying the "rent".

PERSONNEL RECORDS

1. Are targeted case managers required to have the TB test, CPR, criminal history check and auto insurance information?

   Yes.

2. Are the personnel requirements (job descriptions etc) any different for large providers versus a one person TCM entity?

   No.

3. 6-16-2 (4)…process for feedback from individuals receiving services from the employee or agent. What is the expectation or best practice? Will we remain compliant with labor laws? (info must be job related)

   The expectation is that there is a system in place for evaluating performance that includes a process for feedback from individuals receiving services. 460 IAC 6 does not dictate what this process is.

4. For training of staff, it says agendas need to be kept in their personnel files. Is it acceptable to have agendas kept central for reference and just document the date and time for each topic in the personnel file?

   460 IAC 6-15-2 indicates that there is to be a personnel file for each employee or agent that contains the specified information.

5. Is the need for auto insurance for both personal vehicle and/or company vehicle? Our company provides insurance and personal vehicles are not used.

   460 IAC 6-15-2(b)(3) indicates that auto insurance is needed is you will be transporting an individual in your personal vehicle.

PHYSICAL ENVIRONMENT

1. If home needs to be cleaned, painted etc. who pays for this? If home needs fire extinguishers etc. who pays? Can Medicaid support this rule?

   460 IAC 6-29-2 indicates that environmental and living arrangement support is provided to assure that services are provided in a safe environment, with an assessment every 90 days. If an environmental assessment determines that an environment is not safe, the provider is to take appropriate actions. The emphasis here is on assuring that the individuals we work with are receiving services in a safe environment.

2. So what do we do with those individuals who by their own decision, will never meet these standards? Their home will never be clean etc.

   It is understood that not everyone's values regarding cleanliness are the same. However, a certain standard is required to assure that the unclean environment does not pose a risk to the health and safety of the individual and that providers of services are documenting steps taken to support the individual to live in a safe and healthy environment.

3. What if the local ordinance requires a different time frame for testing fire extinguishers?

   Unless the local ordinance is more frequent than the annual requirements set forth in 460 IAC 6-29-4(d); then these standards must be adhered to.

4. Does there need to be documentation in the home that the fire extinguisher and smoke detector were inspected?

   460 IAC 6-17-3(b)(11) indicates that the individual's personal file at the site of service is to contain all environmental assessments conducted during the last 60 days. This would include appropriate documentation of inspections.

5. What if an individual would not be able to appropriately use a fire extinguisher? Should it still be appropriate to have one?

   Yes, 460 IAC 6-29-4(d) does not exclude any individual.

6. If the person lives at home with parents and does not receive services there, does TCM still monitor physical environment?

   If the parents are identified as providing environmental and living arrangement supports for the individual, then this would not be surveyed. However, the targeted case manager has a responsibility to assess any related health and safety issues.

7. If someone needs an anti-scald device who pays for it? Who assures it is installed, hires contractor etc.?

   The waivers and state line item funding can provide for anti-scald devices. A memo will be coming out on this shortly.

8. Should home with MFC have smoke detectors and fire extinguishers? If not, how should it be addressed?

   These standards do not apply to the Medically Fragile Children's Waiver. However, it is important for the case manager to assess any related health and safety issues.

9. Should there be smoke detectors and fire extinguishers on each floor?

   460 IAC 6-29-4(c)(2) indicates that smoke detectors should be placed in areas considered appropriate by the local fire marshal.

10. How are “offensive odors” and “good repair” defined?

    460 IAC 6-29-2 does not provide specific definitions of these terms however, the assessment of the environment should assess and health or safety issues that may be present as a result of offensive odors etc.

11. The family lives in a home that is rodent infested, poor condition yet refuses to move and family neglects to clean up – what happens when BQIS comes in?

    Surveyors will look for documentation to assure that the provider identified as responsible for environmental support is documenting the steps being taken to support the family and steps taken to determine that the individual is not at risk due to the environment.

12. Are physical environment rules necessary for in-home services e.g. respite only?

    Yes, 460 IAC 6 applies to all supported living services and supports, which includes respite care services.

13. 460 IAC 6 does not include carbon monoxide – where in the ISP rule it is. Is this an inconsistency that needs corrected?

    It is correct that 460 IAC 7 does cover the requirement for carbon monoxide detectors. However, it is anticipated that 460 IAC 7-5-8(b)(2)(B) (the ISP rule) will include carbon monoxide detectors.

PROTECTION

1. Are we to call the Nurse Aide Registry for possible findings on every person we have?

   460 IAC 6-10-5 indicates that a report must be received from the Nurse Aide Registry verifying that each employee or agent involved in the management, administration, and provision of services has not had a finding entered.

2. Sometimes it takes a month for a limited criminal history check to come back from the state. Do we need to get a local check done to get them in the home quickly and wait for the state check or do we have to have the state check back first?

   460 IAC 6-10-5(a) indicates that there must be a limited criminal history check. A provider must wait to have this check.

QUALIFICATIONS

1. What are the qualifications for individuals completing the BQIS surveys?

The lead surveyor will meet the requirements of a QRMP and have been trained in BQIS policies and procedures and in conducting surveys.

2. I had a query from an agency regarding targeted case manager education qualifications. Is an education degree allowable? Does it fit into the related field category?

   Yes.

QUALITY ASSURANCE/QUALITY IMPROVEMENT SYSTEMS

1. Will the providers of other services be allowed the same latitude to look at and review an individual's information at another service provider as targeted case manager's are allowed?

   This is not addressed by 460 IAC 6.

RECORD MAINTENANCE

1. If on Support Services Waiver – day services only – do we have to have a log (who comes to visit) in their home?

   No. The only services being monitored are those which the individual is receiving. In this case there are no services being provided in the home so no log would be required.

2. There are instances in which we leave this info but when we come back it is gone – will we be cited?

   Yes. It will be important to document any problems encountered.

3. Believe that records should not be kept in some homes as there are times where staff or others have taken or used records to exploit the individuals that we work with e.g. get access to social security numbers or blank checks etc.

   460 IAC 6-17-3 identifies what must be maintained at the individual's residence or primary location where the individual receives services. The standards lay out guidelines for keeping records in the home. If there are security problems in the home, this is an issue that the appropriate provider needs to document and address.

4. We have individuals who are in several services within one agency and each component has a file. Does this mean that there should be one central file?

460 IAC 6-17-3 indicates that a personal file is to be maintained at the individual's residence or primary location where the individual receives services.

5. Will direct care providers have access to a targeted case manager's quality assurance and quality improvement procedures, as needed?

   There is no provision for this in 460 IAC 6.

6. What is a provider's responsibility to maintain copies of record for individuals in their care? Do records need to be maintained if the individual goes to a different provider?

   460 IAC 6-17-2 indicates that providers are to maintain records for up to seven years.

RIGHTS

1. How do we monitor the person's rights such as "using the phone", "choosing what they eat", "opening their own mail" when they live at home with their parents?

   You monitor how people are doing in homes with their parents, and you discuss issues of concern, but you let the parents make the final decisions.

2. What about choice? Can BDDS tell a person where they have to live?

   According to Indiana Code, BDDS is the ultimate placement authority, so in cases where eminent danger exists, some unusual placement decisions may be made, but all attempts at providing choice will be attempted before any permanent decision is made.

3. How deal with agencies that have vans and park one at an individual's home and then scheduling takes place from that location?

   460 IAC 6-10-11(2) indicates that a provider can not conduct business operations not related to services to the individual in the individual's residence.

4. Is it an invasion of rights when providers are low on staff and combine individuals from two homes to one home?

   Yes.

5. How are individual rights protected for individuals in AFA or AFC? And in the future what role will BQIS play in the lives of these individuals?

   Individuals residing in AFA or AFC settings are covered by 460 IAC 6.

6. Should an individual be restricted from smoking in their own home, where they pay rent, due to the residential provider having a smoke free work environment?

   The support team should consider this issue during the person centered planning process. There is no provision in 460 IAC 6 that would prohibit a provider from having such a policy.

SAFETY

1. We have no right to tell people what can and can not be in their own homes. All we can do is report unsafe conditions. I would not appreciate some stranger coming in and telling me that I needed to get rid of my throw rug because it may catch on fire!

   As stewards of federal and state dollars we have a responsibility to assure that standards are in place to assure the health and safety of individuals.

2. How do we as a provider go into a family's home and tell them they have to have a fire extinguisher, go in and do an emergency evacuation etc.? Is this right for the family?

   460 IAC 6-29-4 and 5 identify that the provider identified in the individual's ISP as responsible for providing environmental and living arrangements is to comply with the building and fire codes and safety and security policies and procedures. If a family is responsible for the safety needs, then the standards do not apply. However, the targeted case manager is responsible for educating the parents/family members and documenting such efforts to assure that health and safety issues are addressed.

3. Are we really supposed to check the water temperature in a family home to make sure it does not exceed 110 degrees?

   No.

4. What if water temperature is not warm enough?

   As an individual's TCM/advocate, it would be acceptable to notify the provider of environmental and living arrangement with a concern about water being too cool.

5. Need more details on anti-scald – does it take a plumber? Who is provider?

   Information will be coming out from BDDS and BQIS on this issue.

6. If all of the individuals in a home are unable to adjust their own water temp can we set it a bit higher than 110 degrees? I see no risk on the individuals scalding themselves. If so, do we have to address the issue in the ISP or on the plan of care?

   460 IAC 6-29-4 indicates that an individual's living area will have an operable anti-scald device or have hot water temperature no higher than 110^{o} F if required by the individual's ISP.

7. Is there a concern with a company locking the thermostat in a home so that the house staff can't get to it to adjust it? I can see some potential problems with this.

   This is not specifically addressed in 460 IAC 6, however it is recommended that at least one staff person have access to the thermostat for safety reasons. It is also recommended that other options be explored versus locking up the thermostat.

8. Do we need to require parents to complete evacuation drills if their child receives services?

   If a family member is responsible for the environmental and living arrangements then this is not required. However, the targeted case manager needs to assure that any health and safety issues are addressed.

9. If noted in ISP that an individual does not need anti-scald devise, it is still required? In family home do they need to install this devise? Where should this be documented?

   No, an anti-scald device is not required. It is up to the individual's support team to determine the need. If the individual is able to mix water and the team does not feel that an anti-scald device is needed, then this should be documented. If the family chooses not to adhere to the recommendation of the support team then this should be documented. It is also important that the family understands the rational for the team's recommendation and that this be documented.

10. Have hot water temperature no higher than 110 degrees, if required by the ISP? So if it is not in the ISP, it is alright for the water to be over 110 degrees?

    Yes, as long as an assessment has been completed.

11. Do written goals provide sufficient documentation toward working with an individual toward properly maintaining their home?

    This would have to be determined on an individual basis.

12. Do the environmental standards apply if only receiving “day” services?

    No.

SANCTIONS

1. If a provider through non-compliance is no longer authorized to provide services, it is a “given” that the targeted case manager will go right to work to find a new provider? What is a guideline for how many days before the individual has to leave that provider?

   It will up to the individual’s support team to work on finding alternative services. The targeted case manager will play a major role in this due to their responsibilities in monitoring services. In addition, the BDDS Service Coordinator will play a role as placement authority. The timeliness of moves will be dependent upon the urgency of the situation.

2. Regarding discontinuation of services – how will this happen to an individual?

   The sanctioned provider will be replaced with a provider in good standing.

3. Where will individuals go to live or temporarily stay if they are removed from a home because of serious endangerment?

   Each case will be different depending upon individual needs.

SEIZURE TRACKING RECORDS

1. I have an individual whom I am worried about as far as his seizures. I am not sure if staff documents every seizure. How can I monitor them when I am not around him but 3 times a month? If I ask him on the day it happens he would tell me, he has short-term memory loss and can not always remember day to day. What can I do as far as the tracking record and staff filling this out? I think the main problem for the staff is they do not want to hassle with the paper work.

   The provider responsible for health care coordination is to develop a system of seizure management for the individual. This system is to be communicated to all providers. With this system the targeted case manager should be able to monitor seizure activity. Contact should be made with the provider responsible for health care coordination services to share any concerns that the system is not be implemented appropriately.

2. Do parents need to comply with 460 IAC 6-25-7? How does the targeted case manager monitor this service if done by parents and the doctor?

If the parents are indicated as responsible for health care coordination, then the requirements of 460 IAC 6-25-7 do not apply. It would be the responsibility of the targeted case manager to work with the family to assure that systems were in place to assure the health and safety of the individual. If there is considerable seizure activity then it is recommended that the support team consider the need for health care coordination services.

3. Is it required that parents of an individual, with whom the individual resides, use a seizure tracking form for documenting. Is it appropriate for the targeted case manager or support team to develop an informal seizure management plan and attach it to the ISP with support team members to monitor for individuals not requiring formal health care coordination services?

   If the parents are indicated as responsible for health care coordination, then the requirements of 460 IAC 6-25-7 do not apply. Based upon individual needs, it may be appropriate to establish informal supports for monitoring.

SUPPORT SERVICES WAIVER

1. What if a person wants assistance/support visiting so they can understand what medical information is given at appointments with the doctor? No Personal assistance is allowed under the Support Services Waiver. How as a Targeted Case Manager can I make that happen? Can a provider do it under Health Care Coordination?

   Yes, a Health Care Coordinator can bill for physician consultation.

2. What if a person wants some very limited residential based services such as cleaning, budgeting, writing bills, but they have no other funding besides the Support Services Waiver and the Support Services Waiver will not allow residential based habilitation services?

   Cleaning, budgeting and assistance with bills is not covered under the support services waiver. If an individual is involved in a day habilitation program, that program may be able to address these issues.

3. The Support Services Waiver does not cover residential services but on the other hand we are supposed to check their home safety and go to their home? If a Targeted Case Manager has to monitor their homes under the Support Services Waiver, why are there not allowances in the Support Services Waiver to allow residential help when needed and there are no other funding resources?

   It is the responsibility of the targeted case manager to assure that any individual receiving services through the support services waiver has his/her needs considered under the person centered planning process and that all health and safety issues are considered.

4. Individuals receiving supported services – will BQIS monitor them?

   Quality monitors/coordinators will monitor people receiving services on the support services waiver using a standardized survey tool.

5. Would any home visits be required for people not receiving any services in the home (e.g people on Support Services Waiver not receiving respite?) What standards apply to people not receiving residential services?

   460 IAC 6-19-6 includes the expectations of monitoring for targeted case managers.

6. I really need specific regulations and standards that must be followed for Support Services Waiver. Many of the standards require more than families' can or will provide.

   460 IAC 6 applies to all individual's on the support services waiver.

7. If an individual lives with parents and is receiving no in-home services, is the targeted case manager required to consider physical environment?

   If the parents are indicated as responsible for environmental and living arrangement, then the requirements of 460 IAC 6-9 do not apply. It would be the responsibility of the targeted case manager to work with the family to assure that systems were in place to assure the health and safety of the individual.

8. Where does the Individualized Support Plan belong when receiving services on the Support Service Waiver and no services received in the home?

   Primary location where the individual receives services.

9. If a person on the Support Services Waiver lives with family and has seizures or special diet, do they have to receive health care coordination?

   This is a decision that the support team needs to make.

10. Do targeted case managers need to take case management orientation if they are only targeted case managers for Support Services Waiver?

    Training requirements are applicable to all targeted case managers, regardless of the source of funding for the individuals they work with.

11. Can a married couple on the Support Services waiver have a joint banking account?

    Yes. Medicaid guidelines for married couples will be applied.

SURVEYS

1. Monitoring includes all providers - does this include guardians or those not paid by supported living programs?

   Guardians are not considered a provider and will not be subject to monitoring. Monitoring will only occur with approved providers.

2. After "site inspection" will the "written report" also be submitted to TCM?

   Yes, the targeted case manager will receive a copy of the results of any onsite survey. In addition, the targeted case manager will also be surveyed.

3. What is the course of action when an individual or family member requests that the BQIS staff not come to their home?

   BQIS Staff will not enter the home. They will notify their supervisors of the request. The supervisors will consult with service coordinators and gather other necessary information. A decision as to how to proceed will be made at that time.

4. What is the appeal process if the provider disagrees with the plan of correction developed by BDDS or the timelines established for correction?

   BDDS/BQIS does not write any plan of correction. It is the role of BDDS/BQIS to issue a written report that identifies necessary corrective action. The provider then must complete a plan of correction to the satisfaction of BDDS. A provider can file for administrative review of any action or determination of the BDDS.

5. Will there be some unannounced surveys?

   Unannounced surveys may occur when complaints are investigated.

6. As a targeted case manager – a quality monitor has never invited me to participate in s survey. When will this begin? Who is responsible for inviting the team?

   The BQIS staff person conducting the survey will notify targeted case managers of surveys. BQIS staff will try to work with both the provider and the TCM in agreeing on date and time for the survey. The TCM should notify other providers as applicable.

7. Are there plans to survey home health agencies?

   Yes, they are considered as providers.

TRAINING

1. Do targeted case managers also have to have CPR etc.

   Yes.

2. Does this mean that staff are required to know American Sign Language if that is the individual's mode of communication?

   Yes.

3. How does staff training prior to working in the home apply to emergency situations?

   The is no stipulation in 460 IAC 6 for emergencies.

4. Is there a specific requirement providers have to do for medication administration such as Core A and B?

   Staff must be trained to administer medications as related to individual's needs. There is no specific requirement such a Core A and B.

5. Negative TB test to be updated in accordance with the Centers for Disease Control – what is the current recommendation form CDC? If it changes – would it be mentioned in a bulletin or do we have to check with the CDC?

   460 IAC 6-15-2 indicates that an individual must have a negative TB test prior to providing services. The recommendation of the CDC is that individuals residing in their own homes are not a high risk population so further updates to the TB screening are not recommended.

6. How does a provider recover the cost of providing all the training to new staff?

   There is nothing in the standards to address this question. This is considered a cost of doing business. It is hoped that retention of staff may increase with increased training and therefore reduce some costs.

7. Should providers refer to the document that Hamilton Center put together in terms of best practices?

   This was an early attempt to develop standards for supported living and can be used as a resource. However, 460 IAC 6 are the fully promulgated standards for supported living services and supports.

8. Staff training on task analysis – who must be trained? All direct care staff or just the individual responsible for writing and monitoring goals?

Any staff who will be teaching/training the individual will need training on how to use a task analysis.

9. Does health and safety training have to be completed before staff work with an individual?

   Yes.

10. Is there a set number of hours that are a part of the training needed for direct care staff? Do you have to have an approved curriculum?

    There is no set number and curriculums do not need to be approved.

11. Are there training requirements for O.T./P.T. staff? If not, why not?

    Physical therapists and occupational therapists have their own credential/licensing requirements.

12. Why are there requirements for targeted case managers for training every year, but for direct care staff once and others have none?

    460 IAC 6-16-3 indicates that there is to be a written training procedure for all new employees or agents and a system for providing annual in-service training.

13. What are targeted case managers supposed to do when they know a residential provider is using substitute staff on a regular basis to provide supervision and they have not been trained on the individual's needs.

    Every attempt should be made to resolve this at the local level. If there is no solution then a complaint can be made to the Bureau of Quality Improvement Services.

14. Can individuals be in the home prior to receiving all their training if they are not responsible for any individuals? There is a lot of value to job shadowing activities.

    460 IAC 6-14-49(d) requires that applicable training is to be completed prior to any person working with an individual.

15. If we are to insure that all staff have received either Core A or an alternative medication training class prior to 1/3/02 – can we initiate annual retraining of the required medication topics effective 1/1/03? For example, if a staff completed CORE A in 9/01, can we initiate annual retraining in 2003 or do we have to insure that the staff person was retrained in 2002?

    There must be evidence that staff were trained within the past year.

16. If staff received training in 2002 on required topics (Rights, Dignity, Abuse, Neglect etc) but the documentation of the training is not exactly as required by the Medicaid regulations, can the existing documentation suffice for this year? If that documentation includes curriculum outlines and certificates of completion, will that meet the intent of the regulations for this year? All future training will be documented on forms that meet specification of the regulations.

    There must be evidence that staff were trained within the past year and any gaps should be filled.

17. In regards to the individual specific training topics, our supervisors have always been responsible for training staff on these specific issues. However, documentation has not been consistent across all divisions and all supervisors. If some type of documentation of individual specific training does exist for individual staff members during 2002, is this sufficient to meet the intent of the regulations for this year? All future training will be documented consistently on forms that meet specifications for the regulations but again, our concern is regarding this type of training already provided this year.

    If there is no documentation of training within the past year, then staff must be retrained and documentation available.

18. If certain training is required, how do we find out about this?

    BDDS will be putting out information on required training.

19. How long do targeted case managers have to complete BDDS approved case manager orientation?

    This orientation is not required at this time, Additional information on training for targeted case managers will be forthcoming.

TRANSFER OF RECORDS

1. Do we transfer 20+ years of records? Are there things that can not be transferred legally? Can we charge?

    The standards do not address charging fees for copying records. Providers are advised to follow applicable laws based on the type of provider that they are and HIPPA requirements.

2. When the “old” provider turns over the records to the “new” provider, are photocopies acceptable so that the original providers records can be preserved?

    Yes, photocopies are acceptable.

OTHER

1. Can an individual be a volunteer for a community organization and be accompanied by staff from a day program (who is paid staff)?

   More information would be needed in order to respond to this.

2. Can targeted case managers be sued by state agency or by a parent? Are there standards to protect us? If a client dies, for example, can we be sued?

   Yes – targeted case managers can be sued. Following the standards will obviously help protect them. However, if a targeted case manager is negligent they can be found liable.

3. Tell me how this is less restrictive than ICF/MR group homes. It seems that all we are accomplishing is establishing smaller group homes.

   The ISP is the driving force behind the standards and is based upon the person centered planning process. The intent is to provide standards for supported living services and supports to better assure the health and safety of individuals receiving services.

4. Is there any work being done to specifically identify what is and is not billable as a targeted case manager?

   The Bureau of Developmental Disabilities Services is currently working on this information.

5. Are the standards written in conjunction with the DD waiver manual?

   Every attempt is being made to align the provider standards rule, the ISP rule and related Bureau policies and manuals.

6. Do the providers of service e.g. behavior, residential and day services need to provide written documentation of progress of individual to the/at the 90 day review IDT?

   Yes, it is essential that the entire team be appraised of progress relating to the strategies and activities that an individual has chosen.

7. What about the possibility of standardized forms for all providers, such as goal tracking sheets, water regulation skills assessment, seizure reporting forms etc. This would allow everyone to know the same way to do things.

   At this time there is no consideration of standardized forms other than the ISP.

8. Impact HIPPA?

   It is understandable that one of the concerns raised about the providers standards rule has to do with the requirement that records be kept at an individual's home and possible HIPPA problems. Providers need to make sure that they comply with HIPPA and the rule. Providers will need to do the following (and probably want to do this in conjunction with their attorney):

   a) Determine whether or not the provider is a covered entity, or other organization to which HIPPA applies.

   b) If HIPPA applies, the provider is going to have to determine whether or not "sharing records" is a disclosure under HIPPA, and if it is, what type of disclosure it is, i.e. whether the disclosure is one of the "permitted use and disclosures" or if it is not a permitted use and disclosure" whether or not the disclosure is of the type for which consent is required. The provider is also going to have to determine what kind of notice, if any, needs to be given to individuals about disclosures and whether or not the type of disclosure that takes place is the type of disclosure the provider needs to log or otherwise keep track of. Depending on the type of provider, the answer to these questions may be different.

   The bottom line is there is nothing in these rules that requires (or suggests that) providers to violate HIPPA. Providers are going to have to comply with HIPPA as it applies to the providers. Providers are also going to have to observe the Indiana medical records confidentiality laws, and for some providers, the Indiana mental health records laws.

9. Are targeted case managers required to have case management folders/books in the home as they are piloting in District 1?

   Not at this time.

10. As Quality Monitors – should we not be certified by state/CPR and First Aid and if so should the state certify?

    No, not at this time.

11. Can something be written that we can give to a family that explains the requirements of these standards? e.g. required visits, unannounced etc?

    A statement was put into the BDDS consumer guide that explains that there are some requirements, such as visits, that case managers are required to complete.

12. 460 IAC 6-20-1, does this mean that any person with a waiver who attends a workshop is required to have 8:1 staffing?

    Yes.

13. Does BDDS intend to fund providers who become the provider of nutritional counseling services, environmental and living arrangement supports or residential allowance?

    460 IAC 6-4-1 identifies that services and supports that BDDS provides. This listing includes nutritional counseling and residential living allowance and management services.

14. Do the waivers need amended to comply with this rule?

    460 IAC 6 applies to the DD Waiver, the Support Services Waiver and the Autism Waiver.

15. Why don't the standards discriminate between a waiver home and a family home?

    We will consider further clarification in technical amendments.

16. Any consideration for a state wide training for direct care staff?

    This recommendation was shared with the Bureau of Developmental Disabilities Services.

17. Schools accept aspergers DX – state waiver only accepts autism.

    An individual with a diagnosis of aspergers could receive services from the DD waiver if DD eligibility and LOC are met.

18. How can families check references of targeted case managers?

    An individual or family could ask a targeted case manager for references and make these contacts.

19. Will the standards be reproduced in a user friendly format? How will individuals be aware of their rights, process for complaints etc?

    It is important that providers make individuals aware of the process for complaints and their rights etc.

20. What is the effective date of this rule?

    January 1, 2003.

21. Am I correct that this rule only covers dd waivers and not medical model waivers?

    460 IAC 6 is not applicable to individuals receiving services and supports from the Aged and Disabled Waiver, the Medically Fragile Waiver, the TBI Waiver or the Assisted Living Waiver.

22. Will 24/7 staff be allowed a sleeping room?

    Please refer to DD Waiver Bulletin # 29. This can be accessed via the web at http://www.in.gov/fssa/servicedisabl.

23. The word "provider" is used throughout the standards, does that refer to both providers and targeted case managers?

    Yes.

24. If a company is not an employer, do the requirements for personnel files, training, etc. still apply?

    Yes – 460 IAC 6-14 and 6-15 apply to employees or agents of the entity.

25. What are standards for termination of services? 30 day notice? What if alternate provider cannot be established within the timeframes?

    While this is not covered in 460 IAC 6, it is expected that the current provider will provide services until an acceptable alternative is found.

26. How can someone get involved in feedback on current 90-day checklist?

    Contact Chris Newman, Director of the Bureau of Quality Improvement Services.

27. Who do we call if targeted case manager has not seen the person for 6 months? What if individual does not want to change case managers even when case manager is not doing their job?

    The individual's BDDS Service Coordinator should be contacted to see if the problem can be resolved at the local level. If not, a complaint can be made to the Bureau of Quality Improvement Services. The same process should be used if you are concerned that an individual is not getting appropriate services and the individual does not want to change targeted case managers.

28. Is it required for sites to have an emergency food supply.

    No, this is not covered under the rule.

29. Since community habilitation and participation now has been divided into community based and facility based, can training be done in the individual's home? If so, how is it to be billed?

    No. It must be provided outside the home. Please refer to the waiver manuals for additional information.

30. If community habilitation and participation have been authorized, is there any problem with combining individuals from different funding sources (Title XX and waiver) into the same group as long as billing is kept separate?

    That is acceptable.

31. What is the difference between a case manager and a targeted case manager?

    The DD Waiver, the Support Services Waiver and the Autism Waiver do not have case management as a service. For these three waivers, case management is a State Plan service – referred to as Targeted Case Management. The other waivers continue to have case management as a service under the waivers.

32. Is a provider supposed to limit an individual's community trips if the individual's total cost for transportation, including public bus fair, exceeds the monthly transportation reimbursement?

    No. It is expected that the individual will still participate in community based activities as called for in the plan. This is one of the reasons that community based activities receive a high reimbursement.

33. As a special Education teacher, can I provide TCM services to my students as long as the company I am employed through does not provider direct services to them?

    Yes, as long as it is not a conflict of interest with your school.

34. Do there have to be sign-in sheets in an individual's home for the case manager to sign in?

    Per 460 IAC 6-19-7, the targeted case management provider must sign in with the provider of environmental and living arrangement supports.

35. Agencies are currently required to be CARF certified in order to receive state dollars. Do the provider standards replace CARF?

    No, the requirements for CARF certification are unchanged.

36. Is the support team the same as the interdisciplinary team?

    Yes.

37. 460 IAC 6-20-1 indicates that the staffing ration for community based sheltered employment is 8:1 – there really is no such thing as community based sheltered employment services – is this supposed to be facility based sheltered services?

    There is community based sheltered employment services and this standard is correct.